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## CHRONIC PEPTIC ULCER\*

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In the short space of time allotted to me it is obviously impossible to discuss at length the surgical status of chronic peptic, or chronic digestive ulcer. The medical literature on this subject has increased steadily, year by year, since the pathological lesion was first described in 1793 by Baillie and the symptomatology in 1829 by Cruveilhier. From time to time increments to our knowledge of this clinical syndrome have been made, chiefly from the clinical experience of those physicians and surgeons called upon to treat these cases.

The medical and surgical treatment of chronic peptic ulcer is entirely empirical because the etiological factors are unknown at the present time, although an enormous literature has accumulated on the pathogenesis of peptic ulcer. It might be well to state that in this discussion chronic ulcers of the stomach and upper part of the duodenum are included under the head of chronic peptic ulcer, because they are similar in that they are both dependent for their production upon the digestive action of the gastric juice, and most commonly occur in that portion of the gastro-intestinal tract above the entrance of the alkaline bile and pancreatic juice, which is constantly bathed by the acid chyme.

In all probability peptic ulcers are caused by many different factors operating in individual cases, and may be produced in a multitude of ways, just as ulcers of the mouth or leg or other parts of the body. Many ingenious methods have been evolved in the laboratory to produce peptic ulcers experimentally and while most of these methods have failed, the successful ones have borne no relation to the causation of common peptic ulcer in man. It would seem that when one reduces the problem of chronic peptic ulcer to the most simple terms these ulcers result from the continued action of gastric juice upon an area of mucosa which has been damaged, or in which area the normal resistance to auto-

digestion has been lessened, or removed. The exciting cause of a superficial erosion of the mucosa may be one of many that have been suggested in the past such as mechanical abrasions, from substances swallowed; thermal injuries; vascular insults, which include septic emboli, infarctions, anaemic necrosis from angiospasm, and thrombosis; disturbances of motility and secretion due to an imbalance between the sympathetic and the parasympathetic nervous systems; the result of toxins such as following diphtheria toxin and burns; generalized bacterial infections; and so on only to mention the more outstanding possible etiological agents. The multiplicity of these suggestions bears ample testimony to the fact that there are numerous causative factors that may operate differently in individual cases. It would seem that in the stomach as in the mouth there are undoubtedly many insults to the mucous membrane which occur as the result of the ingestion of food and drink, whereas in the individual in which the motility and secretion of the stomach are normal these abrasions of the mucosa are quickly healed, but in the patient in whom there is an underlying profound upset in the physiological action of the gastric mucosa, such as a hypersecretion of hydrochloric acid and pepsin, these small abrasions fail to heal and progress steadily from the stage of acute ulcer confined only to the mucosa of the stomach to one of chronic ulcer extending into the sub-mucous and muscular coats.

Unquestionably the stomach of every normal individual is at one time or another, and more or less frequently, the site of inflammations and acute ulcerations which heal rather promptly, being associated with transient symptoms of dyspepsia and even pain for a short time. When the individual with a profoundly disturbed physiological action of the stomach is subjected to the same types of insults to his stomach mucous membrane there is instead of a tendency to heal, one towards chronicity of the lesion. Although we have not been able to explain this apparently simple phenomenon the answer would seem to lie in the character of the gastric secretion. In other words, it is my opinion that chronic peptic ulcer is a sequel to, rather than a cause of, dis-

\*Read before the Medical Society of Delaware, Dover, October 15, 1930.

turbed gastric function. Lesions of the stomach wall must occur with great frequency in animals and man but the large majority heal spontaneously. This inability to heal a lesion of the stomach might be due to an excess of normal pepsin, which being a proteolytic ferment, prevents the formation of sufficient fibrin in the crater of the ulcer. Without the deposition of fibrin in its base, a fact well known to surgeons from their experience with these lesions elsewhere in the body, an ulcer cannot heal. It is again possible that there is a lack of anti-pepsin ferment, or an absence of that ferment which is also lacking in pernicious anaemia. It seems to me that the solution of the problem of chronic peptic ulcer will be, not in preventing the formation of an acute ulcer or abrasion, but in combating or correcting that disturbed physiological mechanism of the stomach which prevents healing of the gastric mucous membrane. There are, however, some anatomical points about the stomach which are at least interesting, due to their possible relation to chronic peptic ulcer. In the first place, about ninety per cent of gastric ulcers occur along the lesser curvature of the stomach, especially near the pyloric antrum and pylorus. In the second place one might say that all duodenal ulcers occur in that portion of the duodenum above or proximal to the ampulla of Vater. A chronic ulcer of the duodenum below the ampulla has not come to my knowledge. Since the gastric and the duodenal mucosa differ fundamentally in their histological structure and physiological action the striking predilection of these two different structures for the formation of chronic ulcerations must be due to one of the two factors which they have in common. One is that these surfaces are continuously bathed with the acid chyme and the other that these same surfaces are subjected to the greatest amount of trauma from the passage of food. It is likely that food taken into the stomach is first churned about in the cardia, in the fundus and finally in the pyloric end, but when it is expelled the passage occurs chiefly along the *magenstrasse*, or gastric pathway. This pathway is by way of the lesser curvature and is formed by a contraction of the oblique muscular fibres of the stomach which produces a trough-like groove along the lesser curvature from the cardia to the pylorus. The mucous membrane lining this passage is thus subjected to the greatest amount of traumata, excepting that of the supra-papillary portion of the duodenum which likewise is exposed to

the constant battering effect of the rather forceful ejections of food from the stomach. There is also in this portion of the mucosa a relative decrease in the amount of mucous cells, compared to the other regions of the stomach, which secrete an alkaline mucous secretion that not only serves as a lubricant but as a chemical insulator as well. Again, the mucous membrane of the stomach in general is thrown up into folds, due to a redundancy of the mucosa and a rather loose underlying sub-mucous areolar tissue. Along the lesser curvature there is no redundancy of the mucosa because of a paucity of both the latter and the underlying sub-mucous areolar tissue. Thus when an abrasion of the mucosa does occur in the region there would be a tendency of the mucous membrane to retract so that the edges of the laceration or ulceration would be separated. In contrast to this the mean redundancy of the mucosa elsewhere in the stomach would promote healing of an injury by allowing the lips of the wound to approximate each other at once without tension. Thus the normal stretch which the mucosa is under in this region is sufficient in itself to prolong the healing of an ulcerated lesion in comparison to other portions of the stomach wall. In the majority of instances chronic peptic ulcer either in the stomach or duodenum are single however, between five and ten per cent are multiple. In the duodenum the most common form of multiple ulcers is the so-called kissing ulcers, two ulcerations located in opposite positions, usually on the anterior and posterior walls of the duodenum. The venous ring formed by the pyloric vein makes the dividing line between duodenal and gastric ulcer, but as it has been suggested earlier in this discussion and will be again referred to later on, there is probably little difference in the two and they should in all likelihood be treated similarly. Their differentiation clinically and pathologically is primarily of academic interest. On the peritoneal surface the ulcer is usually indicated by a thick white scar which can always be appreciated better by the eye rather than the fingers. The area suspected as being the base scar of an ulcer may usually be determined definitely by gently rubbing this surface and the adjoining peritoneum with a gauze sponge. The scar at the base of the ulcer will become stippled with small red dots and in appearance can readily be distinguished from the normal adjacent peritoneum. Palpation must of course be relied on solely in the event the ulcer is located in the

posterior wall of the stomach or duodenum. Palpation of these posterior wall ulcers is particularly difficult if adhesions with, or perforation into, the pancreas has occurred. When viewed from within chronic peptic ulcers are as a rule quite characteristic in their appearance. They are usually deep but may be punched out, funnel shaped, or terraced. As a rule they penetrate not only the mucosa and submucous areolar tissue but well into the muscular coats. The edges of the ulcer are quite soft and friable whereas the base is hard and indurated, sometimes covered with the oedematous sea weed type of granulation tissue, but more frequently a white indurated scarred base uncovered by granulation tissue or fibrin. Different microscopic layers of peptic ulcers have been described but these are very inconstant.

The symptoms and signs of chronic peptic ulcer of the stomach and duodenum are so well known that only a word concerning these well-known clinical manifestations will be necessary. A very pertinent and trite remark attributed to Moynihan was, "the stomach is so sensitive an organ that it cannot refrain from weeping when its neighbors are in trouble, and its voice may be so loud as to drown that of the others." The "others" of course refer to the gall bladder, pancreas, appendix, and also the disturbance of motility and secretion due to an imbalance of the sympathetic and para-sympathetic nervous systems. It therefore is most important that the clinical histories and examinations of these patients with digestive disturbances possibly or even probably referable to chronic peptic ulcer should be most carefully gone into from the purely medical standpoint before surgery is resorted to. Not only is this true in order to eliminate possible errors in diagnosis but for the reason that many early cases may be thwarted if the patient's activity and diet are properly controlled. It is probable that the great majority of peptic ulcers will heal spontaneously if the patient can be induced to rest physically and mentally as well as be placed on proper diets. It would probably not be very much of an exaggeration to state that 75 to 80% can be treated successfully by medical measures. At least two conscientious attempts should be made by the patient before having recourse to surgery. There are, of course, exceptions to this rather arbitrary rule in the event complications develop such as perforation, or cicatricial stenosis, with obstruction. In which event, the patient should be

operated on at once. In the case of a large hemorrhage, as a rule complete rest, transfusion, only cracked ice by mouth, and other medical measures have proved superior to surgical. In the face of repeated large hemorrhages one may be forced to operate in a usually unsuccessful attempt to find the bleeding vessels, but in most of these cases a simple indirect operation will suffice to stop the bleeding. In all cases of chronic peptic ulcer except in a small but definite minority, the patient should first be given medical treatment. Of course in some instances because of lack of co-operation on the part of the patient or economic necessity long medical treatments are impossible and usually without benefit.

In spite of the most erudite medical measures there is a comparatively small but actually large group of individuals who for some reason unknown do not respond to medical measures and added to this group are also those that have developed complications; those financially unable to co-operate, and finally those unwilling to follow the medical regimen. It is to this group that surgical measures must be applied. This group composed of medical failures, severely complicated cases in which to save a life the surgeon is often forced to perform a fast makeshift operation which otherwise he would not prefer; and finally the un-cooperatives, who will either voluntarily or involuntarily continue to be un-cooperative. The most difficult group of patients, therefore, are those treated surgically and this is as it should be if due allowance is made when the results of the surgical therapeutic endeavors are reviewed. From the accumulated experience of those surgeons particularly interested in operations designed for the treatment and cure of chronic peptic ulcer it has been determined that following certain procedures, namely some form of a gastro-entero-anastomosis, the healing of an ulcer would occur and the patient would become and remain subjectively well with a total remission of their former symptoms. Contrary to previous opinion we now have abundant evidence of an empirical and also an experimental nature which strongly suggests that the most important features of such an operative method are first, that the anastomosis between the intestine and the stomach be made distal to the ampulla of Vater so as to allow a constant reflux of the alkaline bile, succus entericus and pancreatic juice into the stomach. Operations limited to the pylorus or upper portion of the duodenum do not accomplish this object, where-

as gastro-duodenostomy, using the third and fourth portions of the duodenum or first part of the jejunum, does accomplish this greatly desired result. This constant alkalinization of the stomach contents is probably the chief contributory factor towards the healing of an ulcer and the relief of symptoms. Second: that a new opening of sufficient size, eight centimeters, providing adequate and prompt drainage, with a stomach contents is probably the chief contents along another pathway be provided. This new channel should be anatomically or mechanically and physiologically as nearly an approximation to the normal as possible. For these reasons the use of the transverse third or horizontal portion of the duodenum recommends itself as the most logical portion of the intestine to be used in such an operation. An additional attractive feature of this procedure is that marginal ulcer has never been known to occur in the duodenum, whereas it has occurred in from three to twenty-five per cent, as reported from various clinics, when the jejunum has been used. The operative desiderata are accomplished with certainty when such an indirect operation as gastro-duodenostomy is employed and at the same time the hazards, i. e., marginal ulcer together with obstruction at the site of anastomosis, formerly called the "vicious circle," not infrequently encountered following gastro-jejunostomy are avoided by this method.

The radical resection of a large portion of the stomach should be reserved exclusively for those cases in which the more simple indirect type of operation proves inefficacious. It will be found that this group reserved for the more radical procedure will be small indeed. Equally good results have been obtained for gastric and duodenal ulcer by the use of the gastro-duodenostomy alone, making the usual procedure of resection of the ulcer at least an optional one.

DR. W. E. BIRD (Wilmington): I was very much interested in the doctor's paper. I think he presented the subject very forcefully and concretely. I have stuck rather routinely to the operation of gastroenterostomy in my own work. In ulcer cases, I have been rather loath to do a gastroduodenostomy, partly for fear of fistula. Duodenal fistula is a terrible condition to have to face, and while there seems to be a little improvement in the method of handling it, due to Potter's scheme of bathing the wound with olive oil, beef broth and hydrochloric acid, nevertheless, the condition of duodenal fistula is a

very distressing one, and I should like to ask what, if any, percentage of cases following this operation have developed duodenal fistula.

DR. GEORGE W. VAUGHAN (Wilmington): I should like to state here that in reading over the Mayo Clinic numbers for the last year and the year of 1929, we get the information and the impression from no less a source than the Mayo Clinic that they regard practically all gastric ulcers as potentially malignant. A gastric ulcer that is demonstrable by xray is regarded by the Mayo Clinic as malignant, and this pendulum seems to swing back and forth. I want to know where and how we little fellows are going to get off. Where must we look for advice? We have the advice that perhaps 5 per cent of them become malignant, emanating from the great Johns Hopkins University, while in the reports of last year and the year before the work of Manning and Goldberger is apparently substantiated by the research work and follow-up system, and they state that they can prove conclusively that all gastric ulcers are potentially malignant. You see the situation that it brings about. It places all of us in a conundrum as to just what to do.

Of course I believe every surgeon, when he gets into the abdomen and finds the conditions, must be capable of deciding then and there what is the best type of operation to pursue. There are many factors that must be considered. The surgeon, realizing the age of his patient, the physical condition, probably will decide on the operation which will be least time-consuming and least hazardous so far as the ultimate result is concerned.

When Dr. Rienhoff was speaking about the pain caused by gastric or duodenal ulcer being due to clenching within the stomach, the question came to my mind that it probably was due to the spasm of the muscle and was not due to hydrochloric acid, as it would seem, having placed hydrochloric acid in the stomach with no resultant pain. If it can be proved definitely that it is due to muscle spasm, due to increased gastric pressure, I am wondering why these gastric patients, the patients with gastric ulcers, the patients with duodenal ulcers, with an increased acidity, experience immediate relief upon the ingestion of soft, bland, or liquid foods.

Does that not increase the gastric pressure? Does that not distend the gastric muscle more than it was before the ingestion of the food? Those are little things I just can't quite get

through my mind as being the real explanation for it.

DR. WILLIAM GERRY MORGAN (Washington, D. C.): Dr. Rienhoff's presentation is one of the best I have heard in a long time. It is a very fair presentation coming from a surgeon and I think that he has brought out very many points that are of importance.

So far as the etiology goes, we, as Dr. Rienhoff has said, the majority of men, feel that it has different causes. There is one thing that we do know, and it is this: There is always a localized lowering of tone and resistance where the ulcer forms. That must come first, some damage, some trauma in one way or another.

I am very much interested to hear Dr. Rienhoff's conclusions as to the best operative procedure, rather, the best treatment. It is true that no one method, whether it be medical or surgical, cures all of the cases. It is true also that in our medical failures the surgeon has come in to make our appearance before the public at large very much better than it would be if we didn't have the surgical procedure.

I, for one, have been loath to accept the partial or total excision as the answer to the surgical procedure. It takes out of the body a part of the digestive apparatus that God Almighty intended should remain there. The less mutilization we do to a patient from any surgical procedure, the better it is for the future of the patient.

He spoke of the criticism in gastroenterostomy as 5 per cent marginal ulcers. That is the general experience of all men who are doing this line of work. In our experience in Washington, we have not had to have a secondary operation done for the cure of as large a proportion of those marginal ulcers as is often advised. We find that about one out of three marginal ulcers can be healed medically without surgical intervention.

Surgery of this type is done by a great many men of different degrees of surgical skill. A gastroenterostomy can be undertaken and carried forward successfully by men who are less skilled in the more radical steps of surgery, as I said, with a greater degree of safety. From that standpoint alone, it can be advised, but the end results we find are better. We have disturbed the anatomy and the physiology of the alimentary tube very much less than in any other procedure.

We don't have developing secondary disturb-

ances from gastroenterostomy as we do from some other procedures. In gastrectomies we have found a certain percentage of cases develop an intractable diarrhea, a diarrhea which is very difficult to overcome, and we have seen cases go on to an untimely death, due to an uncontrollable diarrhea from this source, with a complete dehydration of the individual.

Then there is another point: the after treatment from a gastroenterostomy is not nearly so difficult nor so prolonged as the after treatment where you have a considerable portion of the stomach taken out.

Those who advocate partial or total gastrectomies will tell us that in an incredibly short time the patients can be fed and go back to their normal way of eating and living all right. That has not been so in my experience. I have found that these patients are more or less permanently handicapped, and from the gastroenterostomies we have not had much trouble later on. They assume their normal way of living. It is a fact that anyone who has had a peptic ulcer must be careful and is more or less handicapped all the rest of his life, but I often tell these individuals that they are really not more handicapped in their manner of eating and drinking than they should have been before they had the ulcer; in other words, most of these people who have developed ulcer, have been guilty of more or less gross indiscretions before they had it, and it was the result of indiscretion.

Dr. Rienhoff has brought up a point in which I am interested and concerning which I talk a very great deal, and that is the use of so-called roughage. That is a very dreadful term. It leads people into all manner of serious eating indiscretions and it is true that certain of these cases develop their ulcer as the result of adopting a diet with an excess of so-called roughage. There are certain foods which I believe should never be eaten, and I presume every man here is going to differ with me when I say that the outstanding offender in this class is bran. I believe that bran, shredded wheat, and foods of that type are not only sometimes, and maybe often, the cause for the first trauma developing peptic ulcer, but that they are often one of the chief causes for the development of ulcers low down, the intractable chronic colitis, and even though they are taken with a laudable intent, the desire to relieve constipation, the end results are uniformly bad.

My time is up, but I want again to congratulate you. I think this has been a very compre-

hensive and impartial discussion of a very important and interesting subject.

DR. W. F. RIENHOFF, JR.: Thank you, Mr. President, Dr. Bird, Dr. Vaughan and Dr. Morgan! I thought maybe I was going to get some backfire from the gastric ulcer, and I will say to Dr. Vaughan right now, while this is open, I was just as much surprised about the gastric ulcer malignancy as evidently Dr. Vaughan has been, because, having worked under Dr. McCarthy and known him very well, I was swung more or less over to the idea that these peculiar-looking cells were definitely pathological criteria of malignant change, and many a one I looked at with Dr. McCarthy. When I came back under Dr. MacCollum, he said, "It is nothing but distortion from chronic inflammation, with contraction," and when I read those statistics and others, and we followed our own cases, I personally came to the conclusion that certainly 67 per cent is too high. It may be higher than 5 per cent. The middle of the road is usually where you finally end up, but to do a large, mutilating operation because you think statements which held true twenty years ago may still hold true, may not be open-minded.

This is the October number of the *Annals of Surgery*, in which Dr. Balfour, of Rochester, Minnesota, makes an impressive point in gastric ulcer as to what the extraordinary result might be in those lesions which it would have been a very mutilating operation to remove, and the results that follow a mutilating operation alone. Seventy-nine per cent of those patients reported themselves as relieved of their symptoms and in a great many of them the lesion had disappeared. Now, if 79 per cent of the patients operated on with a simple, indirect methods are perfectly well, it is reasonable to expect 10 or more per cent are not so well, but are still alive, because that is the way statistics run. Then no 78 per cent of them developed carcinoma, and if you take the statistics of carcinomatous ulceration you find at operation, and go over the patients, you will find (we did) that the average duration of clinical symptoms in an ulcerated stomach that was benign was seven years and in a carcinomatous one, it was six and one-half months, and in all cases of this kind there has been malignant change not only around the edge, but in at the base of the cells; furthermore, a great many of those at least had only the peculiar cell changes at one portion of the periphery and not at the base, and I am convinced that certainly 50 per

cent, to be ultraconservative, is too high for malignant change of ulcers of the stomach, and that 5 to 10 per cent comes more near it. I think you have to admit that Balfour wouldn't say this last month, if he were not pretty well convinced of the truth of it.

We have been putting hydrochloric acid in through the stomach tube after a test meal to see if we could get pain from that. This may not be right. It is a sort of hunch that when you do take food, you neutralize the free acid in the stomach and you have an elimination of some of the spasticity of the pylorus, and you have the stomach empty, so you can give bismuth and look through a fluoroscope and see it, if you don't take food, and it is a typical duodenal ulcer, and the patient doesn't get up and take milk and crackers, or soda, he has pain, though he has little fluid in his stomach, but give him the food and it relieves the pain, and when the food goes out, he has his pain again. How else can you explain drainage from increased alkalization and decreased motility of the stomach unless it has something to do with release of the pyloric spasm?

I don't think anybody can be sure what causes the pain. It may be neuritis in the base of the ulcer that we can't stain in the base of an ulcer. I don't know. It is just whatever you think. I think it is mostly due to muscle spasm because you get the same kind of pain and spasm elsewhere in the gastrointestinal tract.

Dr. Morgan spoke of the treatment of marginal ulcer and I talked about it, citing what everybody felt at Hopkins about marginal ulcer. In Baltimore we have treated all ours medically and we have had interesting results, and it is rather interesting that the people who have complained of having pain are more of the psychoneurotic type than the people who haven't complained of pain, and are much more amenable to medical therapy, and when they have gone back on their strict dietary regimen, they have been much better.

Dr. Bird asked about duodenal fistula. We haven't had them. We have had duodenal fistula following an amateur's doing a common duct stone, but I have never seen it from a pyloroplasty or gastroduodenostomy. I have never seen them. If they have had them in Baltimore, I haven't heard of it. It would be a right mean thing to handle.

# EDITORIAL

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### THE RELATION OF DENTISTRY TO MEDICINE

Under the above title the *Dental Roster* for July 4, 1931, contains an article by Dr. Oliver T. Osborne, Emeritus Professor of Therapeutics at Yale University, which briefly but logically expresses the viewpoint of the ultra-progressive wing of the dental profession. We subscribe so fully to Dr. Osborne's views that we quote his paper *in toto*:

[The present unrest in the dental profession in regard to the future of dentistry as an *independent profession* or as a *specialty in medicine* is more than a passing affair. This issue, at the present time as distinct from past efforts to merely require an M. D. degree for dentists, is vitally connected with educational, professional and economic problems affecting the public and dental practice. There is no more and better qualified physician in America than Professor Osborne, who can speak with authority on the question. Dr. Osborne has followed the stomatologic movement closely and has demonstrated a keen interest and love for the dental profession. It may be remarked that the American Society of Stomatologists which at present leads the stomatologic movement in America advocates for the future training of the dentist *three years* in the Medical School with the M. D. degree and *two years* in the Dental School for admission to a dental license.]—Ed.

In the last ten years I have many times discussed this subject and have long believed that the health

of the mouth cannot be separated from the health of the body. Therefore, dentistry is in fact a branch of medicine. Consequently, in my opinion, the dental surgeon should be a graduate in medicine who has specialized in stomatology.

One of the serious problems in the discussion of this subject is the length of time that the medical graduate, specializing in stomatology and expecting to practice surgical dentistry, must study.

A recent article of mine on "Medical Education" (*Medical Journal and Record*, October 1, 1930, p. 329) outlines my belief that the course for the degree of M. D. should be three years instead of four. I believe that in the four-year course there are too many long vacations and too much time spent in laboratory work, and that a progressive course of three years with vacations at the minimum would give as many hours of medical study as are now represented by the four-year course. In these three years the teaching should be concentrated. There should be no unnecessary time spent in laboratories and only such laboratory work should be required as is necessary to perfect the study of anatomy, histology, physiology, physiological chemistry, pharmacology, toxicology, pathology and bacteriology. The specialties should not be taught in this three-year course. After the M. D. degree has been obtained, the medical graduate may continue his studies in any specialty he may desire. If the fourth year for the medical degree is thus saved, the expense of the fourth year is also saved.

It is hardly necessary to outline the importance of the health of the mouth to the whole system. The mouth is nearer to the body than are the eyes, the ears, or the skin, and yet an oculist, an aurist and a dermatologist must have the degree of M. D. to practice these specialties. How can we take any other viewpoint than that the dental surgeon, the stomatologist, must of necessity have the degree of M. D. before he specializes?

With the courses on stomatology now being inaugurated in the first-class medical schools in the curriculum for the M. D. degree, the prospective dentist should acquire a very clear knowledge of this subject. After obtaining his M. D. degree it would seem that one year more to increase his knowledge of stomatology and to teach him the technic of dentistry would be sufficient.

Milton C. Winternitz, Dean of the School of Medicine of Yale University, writing on the subject of "Medical and Dental Education" (*Clinical Medicine and Surgery*, August, 1930), says: "It seems to me, if we fulfill the wish that has been expressed so often by the best representatives of the dental profession, that dentistry will become a portion of medicine, co-ordinated with every other specialty; that the dentist of a generation or two hence will have as broad a knowledge of man as a whole as has the ophthalmologist, the orthopedist, or any other specialist of medicine."

A law requiring a dentist to be a graduate in medicine could of course not be retroactive. Therefore the dental surgeons already licensed must be allowed to continue to practice dentistry. However, there should be some method devised whereby such of these dental graduates who wished to take a post-graduate course to better understand the human body could do so and receive a certificate for such work.

I do not at all approve of licensing dental mechanicians. Their expert work is a necessity for dental success, but if they are licensed it would

give them too much freedom in dental activities. They should no more be licensed than are skilled technicians in medical laboratories.

Graduate dentists should do the oral hygiene work that comes to their offices. Such work represents minor surgery, and minor surgical operations must always be performed by graduates in medicine, and the same thing should be true in dental surgery. I see a great many mistakes made by the so-called prophylactic dental nurses. They should not be licensed; it gives them too much latitude in treating, and attempting to prevent mouth infection. If a dental nurse wishes to become a full-fledged dentist or a skilled technician, let her study the usual courses for these subjects.

The prevention of the loss of teeth and the prevention of dental infection and the early diagnosis of teeth infection represent the highest points in dentistry. The prevention of diseases that emanate from mouth infection is today one of the highest aims in medicine. Therefore, prevention work should be done by a dental graduate and not by any inferiorly educated person.

It is to be hoped that dental colleges will soon cease their opposition to the requirement that a dental surgeon should be a graduate in medicine, as in this requirement we are behind a large number of European nations. The United States, that has long furnished the most skilled men in the art of dentistry, should not be backward in the final perfection of this, today, very important branch of medicine.

#### EDITORIAL NOTES

##### DEAR DOCTOR:

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#### "THE LITERARY DIGEST PICKS A DOCTOR"

Apparently there is still something seriously amiss with public knowledge of the functions of organized medical societies.

A certain C. Houston Goudiss, of the New York *Forecast*, has some excellent ideas about how to tell a quack when he sees one.

Neither he nor a *Literary Digest* commentator seems to know just how to go about picking an honest medical man.

The *Literary Digest* of May 30, 1931, was so much interested in Mr. Goudiss' ideas as published in the *Forecast* articles that it picked them up bodily, adding certain comments of its own and heading the combination with the caption, "How to Pick a Doctor."

Suppose, they say, that you are alone and sick in a big city and there is not even a helpful hotel clerk downstairs to send up the hotel physician.

What can you do to get a responsible properly qualified city substitute for the "old family doc" you left behind you?

How do you pick a doctor, in other words, according to the *Digest* and Mr. C. Houston Goudiss?

Well, here's how: you call the Young Women's Christian Association, or the Young Men's Christian Association, the Young Men's Hebrew Society, the local Rotary Club or the nearest hospital.

This last, says Mr. Houston Goudiss sagely, is your best bet because hospitals of any size, in any community, are required by law to maintain certain standards.

You tell by the following signs whether you have got hold of a quack or not: demands for money in advance; claims of a "special system" for all troubles; claims of some secret remedy or cure. All these should make you suspicious, says Mr. Goudiss. They are prima facie evidence of a faker.

The prima facie evidence of an honest regular practitioner is apparently much harder to describe. You must call this or that or the other lay organization to find out about him, or you must put in a claim for attention from some busy hospital.

These two may be taken to possess at least average intelligence and the average amount of information. What is the matter with the public relations of organized medicine, that neither had apparently ever heard of a county medical society?

They know, for instance, that a reputable practitioner must have got his degree from a reputable school; that he will be a member of reputable medical societies. But they know no simple way of checking up on either of these details.

Instead they counsel the sick, in need of more immediate attention, to call up the welfare organizations or a hospital to get their information second hand.

What about the general public if these men are so grossly uninformed?

County medical societies are enlarging and strengthening their organizations as never before. They are adding special committees for this type of public relation, other committees for that. They are more conscious and better equipped to take care of their public obligations than ever before.

Yet a large section of the public still knows nothing of the most fundamental and elementary

service the county medical society has to offer—that of identifying and certifying honest physicians and protecting the public against quacks.

"Be suspicious," says the Goudiss article, in conclusion. "If you are sufficiently so, you will not entrust your most valuable possession to a faker. And if you insist upon having the facts you will go far towards the laudable goal of discouraging and eventually ridding our land of quacks."

The medical profession should certainly inform Mr. Goudiss just how it is prepared to assist his laudable campaign for discouraging quacks.—*Minn. Med.*, July, 1931.

Bishop Cook, in a letter which he does not desire to have published and referring to the editorial in the May JOURNAL concerning his statement that "Many surgeons are accustomed to use stimulants before they are to perform an operation," states that he is not willing to make any public reply.

At the A. M. A. meeting in Philadelphia last month the official registration figures showed 67 from Delaware, and 78 from California. Comparisons may be odious, but they may also be obvious; from the above it is evident that Delaware fell short of her full duty to herself and to the A. M. A. Let us rectify this in 1932 at New Orleans.

### Loss of Viricidal Property in Serums From Patients With Herpes and Encephalitis

Observations made by FREDERICK P. GAY and MARGARET HOLDEN, New York (*Journal A. M. A.*, June 13, 1931), would seem to indicate that the usual neutralizing action of normal human serum on herpes virus is slightly reduced on the average in herpes that is recurrent, and distinctly reduced during a primary attack of the disease. The serums from acute instances of epidemic encephalitis, although limited in number, show in a large percentage of instances loss of their power to neutralize herpes virus. This loss of neutralizing power occurs less frequently in chronic instances of the disease, although they are still in marked contrast with control cases. These results would seem to indicate a relationship between epidemic encephalitis and herpes simplex and may offer a presumptive diagnostic test for the former, somewhat obscure, disease.

## DELAWARE PHARMACEUTICAL SOCIETY

### DRUG STORE WINDOWS

By LAWRENCE S. WILLIAMS, Phar. D.,  
Baltimore, Md.

As you read this article picture to yourself the impression you think you will make in the minds of your customers if you should follow these suggestions.

If you have a strictly DRUG STORE display that really depicts the true character of your store as a PHARMACY you can rest assured that your customers will take particular notice of it.

Are you one of the many that will let any manufacturer that comes along (whatever the nature of his merchandise) to fill your windows with cartons or cards that he intends to give to the store at the next corner whether he be a tobacconist, confectioner or what not? How can you expect your window to stand out and attract attention?

Make your window display distinctive. You certainly have enough drug store items to make a display that other stores cannot duplicate. For instance atomizers, rubber goods, tooth and hair brushes, tooth paste, household remedies, pressed herbs, etc. Did you ever try a display of herbs? Nearly every one will stop to look at Senna Leaves, Boneset Tea, Sassafras Bark, Chamomile flowers, etc. So many pharmacists have told me, "Oh, I don't have time to fix the window" or "I don't know what to put in so just let those fellows come in and do it." Yet I am sorry to say most of those answers come from men who are sitting around doing nothing.

Why wait for Pharmacy Week or First Aid Week to make such displays? You do not have to have a map of the world to make a pharmacy display six or more times a year. Bandages, adhesives, cotton, gauze can be built into a catchy display that will not be duplicated by other merchants. Pharmaceutical houses will be glad to lend you a vaccine or biological display. Along with it you can place mortars, graduates, prescription bottles and boxes which build up the window to make it look like a drug store window.

A number of you are thinking that by doing this you are not getting a thousand cigarettes or a dozen of something or other, but when you have a pharmaceutical display to attract the customers' attention you are getting them acquaint-

ed with your store as a pharmacy and not as a merchandising mart.

A show bottle hanging in each corner of the window also is a distinctive permanent sign of your store.

People often say there are no more drug stores. Are YOU doing your part to change this attitude or are you continuing to drive the people away because they think you do not want to waste time on prescription or drugs. If you prefer to use your windows and store displays for other than drug store items why not stop advertising prescriptions a specialty, take down your drug sign and discharge your registered pharmacist as he is a big expense if you cannot keep him busy in his profession. You are always looking for something out of the ordinary to attract the customer's eye as he passes your window, aren't you? Here is a way: Take about a dozen or more of your little-used shelf bottles and make a display of them. Place around them the ingredients used in their manufacture. You surely have a percolator that you can put to work, making Tincture of Gentian Compound or Tincture Cardamon Compound. People will always stop to look at such a display.

Would not you be very much surprised to see on display in a jeweler's window anything but jewelry or silverware; or in a grocery store window shoes and socks; or the haberdasher have hardware; the hardware man collars, shirts and neckties? Yet, we as pharmacists, put all of these items of merchandise in our windows and expect the physician to send his patients to us for prescriptions or drug store articles when he is not sure whether we even have them for sale any more, as he never sees them in our window or in evidence in the store.

Bring out some of your shelf bottles and take the top shelf which is always hard to reach and put them on display. You will soon notice the effect and the prestige you will gain with your patrons. Scrape off the ice cream signs, the cigar advertisements and the soft drink wording painted on your windows and replace with a valance bearing the word PHARMACY. I am sure the effect will more than please you and will pay in dollars and cents. I am going to call attention to this phase of our profession at the convention this year, and I want to get some good reports from you.—*The Maryland Pharmacist*, April, 1931.

## MISCELLANEOUS

### The Patient Is Always Right!

Hospitals have become so numerous in the last quarter of a century, and withal so well organized, with intensely trained staff, specialists and nurses, they now run on a system of "technic" and have lost track of the personal care and attention so necessary toward the recovery of the sick. Sympathy has entirely disappeared from their category. That word is now obsolete.

Even where hospitals are operated by different religious organizations, whose teachings were originally disposed to extend sympathy toward the sick; they too have eliminated sympathy and it is all "system" today. The patient who happens to be in a hospital becomes merely a "number" under the system.

System, or technic, is not so pronounced in the nursing homes in England, or the smaller hospitals in Europe, or even in the care of the sick and distressed in Asia, where the greater portion are cared for by loved ones in the home or elsewhere. In any case, the first thought in their minds is individual comfort and care combined with sympathy, which is the basis of the idea inculcated to build and uphold the morale of the sick person, a most necessary factor towards recovery.

Hospitals in this country do not even extend the patient the courtesy ordinary hotels show to their guests and which is drilled into every member of staff, from elevator and bell boy up; all are thoroughly instructed in the business principles which make the hotel popular. The guest receives not only service, but that service, no matter how small, is always accompanied by the utmost courtesy and consideration for the comfort of the individual served, and rendered with sympathy. It matters not what mistakes or errors the guest makes, he is conceded and treated as always right, by the management of the hotel; whereas, in the average hospital anything that interrupts the "technic" or breaks the rules of the institution is immediately laid at the door of the sick individual as a grievous wrong, or error, whether he is conscious or unconscious at the time of the action. In any case, he is "always wrong."

Last winter I had an experience in a hospital in the Northwest. I was attending a convention and owing to the crowded condition was unable to procure a bed or room in a hotel during the intensely cold weather; therefore, asked the cab

boy to drive me to a hospital. On arriving, I was registered, as usual, at the desk. They then intimidated me, as they usually do, relieving me of my bank-roll, telling me they would not be responsible for it otherwise, unless I left it in the safe, and when I read my receipt it stated the money was to apply on my account; certainly an excellent hospital regulation. At an hotel, your money would be placed in a safe for protection, but my hospital receipt also stated the money deposited would also be applied for any discrepancies, or injury that might occur to my room, which equivalent value would be immediately collected from the deposit made.

After arriving at my room, an interne called to take my history and he mistook me for a patient thinking that one of the staff had sent me to the hospital for an exploratory laparotomy, so I was embarrassed by answering every question of what I knew or did not know of my family from my great-grandparents down to the number of children which they might credit me with and all of that was penciled into duplicate copies with an indelible pencil and made a record of that institution.

Every disaster that I had had or missed during my earlier "piety" was also placed into this record. My blood was tapped to make a Wasserman and in fact I considered that I was accused on that paper of having Lues. They milked the prostrate; he said, for the purpose of seeing whether any gonorrhea was lingering from earlier life. I was given a meal that night of crackers and green tea, without sugar, and in thirty minutes by the clock, a tube was passed into the stomach and they didn't allow it to even digest.

While it was practically normal, they collected the urine and gave me what they considered a test to see whether or not I was eliminating a proper amount of urine, and they were not satisfied but catheterized the ureters.

Due to the intensely cold weather, I had developed a slight coryza, and they brought in a consultant and he suggested xraying the sinuses about the front part of the skull and face.

The operation they told me had been planned for early the next morning, as the doctor who was to operate desired to attend an early convention, so instead of making a gastro-intestinal picture from above down, a large colon enema was given and fluoroscope taken from the lower end of the large bowel; apparently to observe the various kinks in the bowel and to find out on which side of the abdomen the appendix rested.

In this intense pain and anxiety I forgot to think of the price of all of this extra work as the embarrassment and pain overshadow the financial loss, until you read your receipt and find out you have a deficit.

\* \* \* When I undressed and got into bed, to my surprise I found it had under the sheet a rubber sheet that felt as though composed of oil cloth, and absorbed more cold than heat. I asked the nurse if she wouldn't remove it that I didn't feel that I could sleep with such an uncomfortable thing under the sheet. She said she would have to get authority from the office. I suggested using the phone, which she did, and after they looked up my account they said it was O. K. I questioned why it required so much red tape to get authority from the office to make me comfortable. She stated that her position depended on her adherence to the "technic" of the hospital, and in this case evidently not for the comfort of the patient and if anything happened that the mattress should be contaminated on account of the sheet removed, the amount would be taken out of the money already deposited.

During that night not realizing the temperature outside, I had inadvertently left my window a little ajar, dreaming that I was in California; I awoke very cold. I pulled the bell; a nurse called and I asked for a hot water bottle to be placed to my feet. She stated that it was against the rules to give out hot water bottles unless the doctor ordered it. In order to appease my wrath, she stated that there had been a number of patients who had burned their lower extremities due to hot water bottles, which had been a source of litigation and embarrassment to the institution, but after all that explanation there was no attempt whatever to make me comfortable, except to close the window.

A prescription which appeared to be amylal was brought in on a fancy platter and tray with a glass of water for me to take on retiring so that I would be prepared for less anesthetic the following morning. I very effectively camouflaged it and allowed the capsule to drop into my sleeve just previous to gulping the water down and then I simply became conscious that I had lost another six-bits or \$1.00 prescription, after which I kept them as a souvenir when the nurse disappeared from the inner chambers. The following morning at 5:00 a. m. I was aroused from my slumbers by a nurse with a bed-pan under one arm and an enema can in the opposite one. She said

that the doctor had ordered an early enema as he desired to operate at 6:00 a. m.

I objected to the entire proceeding and suggested as a compromise that I take it in the lavatory, but she stated that it was the "system" that the enema would pass up through the big bowel better, if it was given in a reclining position, something that I had never had any personal experience with, so I obeyed the "system." After that ordeal was finished I dozed off and at 5:30 she returned with a needle attached to a hypodermic and as I awoke, was preparing my arm along the front of the deltoid to punish me with the needle. I pled with her to let me place it in the abdomen as it was less sensitive. She said that their "technic" called for the left arm and seriously objected to giving it in any other part of the body, but after prolonged consultation with the floor nurses, they decided as I was a doctor that I might have it in the abdomen. While she was preparing the abdomen, I emptied the hypodermic of another dollar prescription and after it was effectively sterilized she emptied the contents of an empty syringe into the abdomen, a fact which I must confess only produced imaginary pain. True, at six o'clock, I had just entered another slumber when two nurses rolled in the gurney and I began to realize that I was facing the inevitable. I implored them to send for the doctor and they stated that he was short of time and was already prepared in the surgery. I pleaded with them and confided that there were some very important confidential messages that I must deliver to him, before I was placed on the gurney. But that good doctor kindly condescended to call and as he entered exclaimed, "This is not my patient!" I had never had the pleasure or privilege of meeting him before, but I felt that he belonged to the same great family of Aesculapius that I did, and I besought him to hear my confidential message and he closed the door and I made an honest confession of how I happened to be in the hospital, to try to keep warm, but I felt I would have preferred freezing outside. After he had dropped on the couch for laughter, his first question was: did I take all the medicine that he had ordered. I explained to him how effectively I had camouflaged the entire output and that it is on the chart and not to tell the nurse, as she no doubt would lose her position if the "technic" was not followed. It mattered little about the comfort or safety of the patient. He called up the office and ordered my breakfast and stated

to them that the operation was "postponed" and he would treat me at the office. No doubt another record was placed down that I was suffering with some disease with which the profession is familiar and surgical intervention contraindicated.

I finished my meal and was in the convention at 7:30. This experience has opened my eyes more than I had ever learned during the last quarter of a century, as to the importance of the patient in the hospital always following hospital "technic." With an individual placed in an uncomfortable bed which he cannot have changed without making a deposit in the office of a few paltry dollars to overcome the possibility of soiling the mattress and in every institution of this country, the worthy nurses are taught and convinced that to do anything for the comfort of the patient, it must first be written out in black and white for them to follow.

There is no doubt but what technic and system are more important in winning battles in warfare. It may be essential in many of the great undertakings where a large number of people are working on great enterprises, but I firmly believe that we are losing sight of one of the most important aspects in the treatment of patients when we place them in a hospital where they are naturally more or less embarrassed at the situation. He is a sick man, he wouldn't be there if he was well. He is placed in an environment which is new to him. He receives nothing from the interne or the nurses but questioning him about things which may or may not have anything to do with his personal illness. His "hide" is punctured at various points to receive his life's blood. Sounds and catheters are passed through every opening from his proboscis to the openings at the lower end of his trunk. They are filled with inflated fluids, with a view of pictures and to conform with what the hospital calls "technic." They continue this line of torture as long as his deposit in the front office holds out, when a slight personal history as to the nature of the disease with physical diagnosis would solve the problem of the average abdominal disease, and why embarrass him by opening up the dark secrets of his past? Why embarrass him over his family history, over a few relations, and disturb his mental equilibrium and possibly impress his mind with unnecessary things which are derogatory to recovery, and when he receives his bill for all of this extra embarrassment and a few days in the hospital, he is in very poor position to stand any

surgical procedure; unless he has had a larger bank roll than I did, they won't operate on him after they make a diagnosis. If he has blood poison, they waste their time injecting the blood in a rat to see what action it will have on a rat, before the poor patient is treated.

If the physician decides to give him a special diet he has got to experiment to find out the proper proportion of proteins and carbohydrates, to know what is best suited and the way that he establishes that, he experiments with rats and finds out that they grow better and develop on about 14 to 18 per cent of proteins. If the patient's condition needs vitamins, it is necessary to feed the rats on various forms of food to see which form of vitamin he needs, and then after the rat grows on a fixed proportion, you give a man so many rat doses to get him to act similar to a rat, and that's "technic."

The State of California is spending millions annually by poisoning and destroying rats in order to eliminate them. The Professor of Anatomy at the University of California, Professor Evans, is raising rats and spending thousands of dollars annually and keeps a whole colony of them at the University, treating them, as he claims whatever is good for the rat, making the rat grow, will cure the man, so he feeds them various kinds of expensive foods at the expense of the taxpayers when the poor people need the money, as he claims he can increase or retard development in the rat by the kind of food he gives it and after the rat is treated, the professor will know how to treat the individual.

The day has practically arrived, when you go to a hospital, if you don't take your rats with you, you will find them on your bill when you leave. In other words, they feed the rat and they take his temperature and find out what's wrong with you. This is all charged at the desk in proportion to the size of the wallet you have deposited when you entered.

It is no wonder to me that the gullible public have largely lost faith in the clan of Aesculapius and their intense scientific treatment; they prefer some doctor like the Christian Scientist, who tells you there is nothing wrong and lets you sleep all night and if you are accustomed to breakfast at eight, instead of rousing you at 5:30 to eat, permits you to sleep.

If, before coming to the hospital, you are a

"night-owl," they close off your lights at 8 o'clock, according to the hospital routine and leave you in utter darkness until the following morning. If you ring your bell and the nurse comes and you tell her it is so early to bed, you can't sleep, she simply reports that the doctor left no order for that and you can't get him until morning.

Instead of the sick person always being right, the hospital today, through their intense "technic" always finds him wrong in everything and if he is only there for a few weeks, they make it very disagreeable for him in trying to change his habits of a lifetime, and he leaves the hospital a thorough believer in the high cost of medical treatment; because he cannot understand why he should divulge everything that has been told to him about his health, why he should tell all of his younger maladies and symptoms, during his entire lifetime, why his treatment should be mixed up with rodents. There is so much "technic" and "science" that he comes out a firm believer in some of the offshoots of regular medicine, which pay more individual attention to him, sprinkled with a little sympathy, and less torture in examination.

If the hospitals of this country wish to succeed with 100 per cent full basis, they should try to make the stay in the hospital of the patient something similar to hotels and to adhere somewhat close to his routine before he went there. They should eliminate some of the torture in examinations which are too often unnecessary. If they are treating his disease with guinea pigs and rats, it should appear on his bill as "booze," and scatter a little sympathy at the sick bed.

It is usually the rules of the hospital that the nurse that goes off at 7 o'clock should have bathed him previous to that. If he is accustomed to sleeping later, break the rules of the institution and allow that part of the "technic" to come after the nurse of the day has arrived. In other words, make the "technic" a little flexible for the sick individual. It matters not what he does, he should always be considered *right*. If he was a well man, he wouldn't be there. Too many of the rules of hospitalization are made for well people and not for sick people. It is no wonder that every hospital is in financial difficulties from "system."

If, in that family history, there should ever have been a case of insanity, no matter from

what cause, you are immediately labeled, "Psychoneurotic." If there has been a syphilitic history, you are placed in that category. If there has been tuberculosis, and you should be at all emaciated, your condition is too often classified as a predisposed factor of the disease. If there should have been a cancer history, or some symptom of cancer, it is readily diagnosed to correspond with the history, and so on with the entire category of "previous history taking" which always prejudices the mind of the honorable doctor in making a proper diagnosis of the individual in his care. In the meantime, that record is placed into the archives of the institution and is often taken into the Courts of the Department of Justice and used in the trial balance which weight may carry you into an unjust analogy. You may state that this history that is placed in the hospital is confidential, but the court has the power of bringing the record before the jury, who may be weighing your case.

It would appear to me if the patient were treated in our hospitals in a more humane manner and with less hospital "technic" in history taking, in his examination; care used to make him more comfortable in his new environment, in disturbing less his time of going to bed and of getting up, in taking his meals, in making his medicine more palatable and associating his disease and recovery less with the "rodents" that have always been considered his enemy; that he could be placed in a better environment for recovery and would no doubt have a happier memory of his visit to the "house of pain," which is considered torture.

In other words, use your power of suggestion to inculcate happier thoughts, a pleasant environment with simple sympathy is often more powerful in recovery of a sensitive patient than drastic drugs.

In fact, if we could only observe mechanical therapy and the various isms of our profession and see the individual workings of Christian Science itself, which inculcates a happy environment, keeps the mind free from harboring any form of disease, in fact using only suggestion in the treatment of diseases of which they are not cognizant, we might learn that there are other elements which contribute much to the recovery of the sick, aside from abstract hospital regime. —Editorial, *Compend of Med. and Surg.*, April, 1931.

### Centenary of Chloroform

This year marks the hundredth anniversary of the discovery of chloroform. Three distinguished scientists working independently, one in this country, one in Germany and the third in France, discovered chloroform in the same year—1831. The American was Dr. Samuel Guthrie, one of our pioneer workers in chemistry, whose name appears in a chronological record that has been submitted for use in staging an historical chemistry exhibit at the 1933 Chicago Century of Progress International Exposition.

The chronological record is contained in a report of the chemistry division of the National Research Council Science Advisory Committee to the Century of Progress management recommending plans for the entire series of chemistry exhibits. The chemistry division is made up of twenty-five leading American chemists who have volunteered their services to the 1933 exposition management:

Dr. Guthrie, according to the chemistry division's record, discovered chloroform on October 12, 1831. It is this event that may be commemorated in an exhibit at the Chicago exposition. Dr. Guthrie's name also appears in a roster of about 100 celebrated persons who have contributed to the development of American chemistry during the past century, which is also a part of the chemistry division report.

About the same time that Dr. Guthrie was making the experiments that resulted in the discovery of chloroform, Von Liebig, the famous German chemist, was working toward the same end, as was also a Frenchman named Soubeiran. Dr. Guthrie was unaware of the fact that his discovery had been made simultaneously until some time afterward.

Dr. Guthrie's discovery was made in Sackett's Harbor, N. Y., while experimenting with bleaching powder, or chloride of lime, and alcohol. He called the product a "spiritous solution of chloric ether." In the same year in which he made his discovery he demonstrated it at Yale, where it received the approval of another noted pioneer in American chemistry, Benjamin Silliman.

The American discoverer of chloroform was born in Brimfield, Massachusetts, in 1782. He was a surgeon in the U. S. Army during the War of 1812. Later he invented the punchlock to replace the old-time flintlock musket. He is also credited in chemistry annals with the origination of a process for converting potato starch

into sugar. Dr. Guthrie died in 1848, which was about the time that chloroform was first used as a general anaesthetic.

It was in 1847 that Sir James Y. Simpson, a noted Scotch medical authority, began in Edinburgh the practice of using chloroform in maternity cases which later led to its extended use in surgery. Dr. Guthrie was honored by the Medico-chirurgical Society of Edinburgh for his discovery.

The National Research Council Science Advisory Committee which is sponsoring the science exhibits at the 1933 Chicago Century of Progress exposition is made up of about 50 of America's foremost leaders in all branches of scientific endeavor acting under the chairmanship of Dr. Frank B. Jewett, president of the Bell Telephone Laboratories. Maurice Holland is director of the committee.

### The Doctors Talk on Nursing

When 756 physicians discussed the nursing question informally, the greatest numbers commented on the fact that there is no shortage in the nursing supply, that registered nurses are generally competent, and that nursing charges are too high from the point of view of the patient.

This open forum for physicians was held by the Committee on the Grading of Nursing Schools, which is studying the problem of providing ample and adequate nursing service to the public, at a price within its reach. When the committee sent out questionnaires to the physicians, it asked them to write their frank opinions on nurses and nursing on the backs of the questionnaires, after the formal questions had been answered.

Of 376 who talked about the shortage question, 281, or three-fourths, said, "There is no shortage of nurses." Of the 318 who discussed the capability of nurses, 264, or eighty-three per cent, said, "Nurses are generally competent."

A smaller number, 171, were interested in commenting on the cost of nursing service to the patient. All but twelve believed the charges to be excessive, from the point of view of the patient. On the other hand, of twenty-seven doctors who commented on the earnings of nurses, twenty-six said they thought the annual income of the nurse is too low.

A composite picture, built up from these informal comments, might be described as follows:

"The registered nurse is generally competent, often positively heroic. She follows orders, uses good judgment, is usually ethical, is skilled in handling people and has a pleasing personality. But she sometimes steps on medical toes by discussing symptoms and suggesting treatments; she could sometimes be more industrious, and show more interest in the patient.

"She often lacks skill in special techniques and picks and chooses cases.

"There is no shortage of nurses. The nurse's hours are too long, and her income too low. On the other hand, charges are excessive, for the patient."

The physicians who took part in this symposium on nursing represented many branches of the profession and came from ten representative states.

It is significant that, when they could talk of whatever they pleased, so many doctors should stress the same aspects of the nursing situation, and that there would be the general agreement that exists among the states.

These informal remarks check with the statistical findings, gathered from the questionnaires of 4,000 physicians. Thus, it was found that only two patients out of each 100 could not find a nurse when they needed one. This is confirmed by the general opinion of physicians that there is no shortage in the nursing supply. Nine out of ten, tabulation showed, answered in the affirmative, "Would you like to have the same nurse on a similar case?" Again, the large majority of those who commented on the ability of the nurse felt she is generally competent.

The grading committee has been studying some of the problems implied in these comments from the physicians. Its findings show that often, probably, the nurse is not to blame because she "registers against" certain types of illness; or that she lacks skill in special techniques. The reports of what the student nurse does in training reveal that important basic services are omitted from her program by many nursing schools, so that, as a graduate nurse, she either registers against such cases, or shows herself unable to perform properly the nursing duties involved in them.

Physicians commented on this relation between the training of the student nurse and the fitness of the graduate nurse to deal with certain types of patients.

An Oklahoma physician wrote: "In this sec-

tion of the country, most nurses have excellent operating room training, but poor bedside training." A Massachusetts physician wrote, "The nursing problem in obstetrics is very acute." From Illinois came the comment, "Psychiatric post-graduate training of R. N.'s is too rare and there are not enough really well-trained psychiatric nurses for private duty."

New York physicians seem better pleased than those of other states with the breeding and personality of the nurses with whom they come in contact. More physicians of Washington said there was a shortage of nurses, than said they believed the supply adequate.

Other matters talked about by the physicians were:

13—"Young nurses are better than old ones."

8—"Old nurses are better than young ones."

14—"Nurses' hours are too long."

14—"The schools should raise the entrance requirements."

9—"The professional registries send better nurses."

24—"She talks too much."

14—"She doesn't talk too much."

Some of the miscellaneous comments were:

"Many good nurses work too hard."

"My worst trouble is that I never know a nurse's name. She is a part of the machine and usually fills the bill."

"I have never had any difficulty in securing nurses in this city or its vicinity. In fact, various registries are continually reminding me that they have nurses on hand."

"This particular nurse is intelligent, observing, not afraid to take a severe case twelve miles in the country, well trained, pleasant but strict in following the doctor's orders in regard to the patient, family, and visits. I have had many nurses like this, and some dismal failures. Financial conditions here are such that we have few trained nurses, but we have very little trouble getting one when required. My experience with practical nurses is not so pleasant. I wish every one of my seriously ill patients could have a registered nurse."

Many physicians took pains to stress the value of the nurse's understanding of the mental habits of sick people, in writing of specific examples of nursing care, and her ability to be intelligent and tactful about home situations.

## Advertising and the Doctor

Although the great American god "Advertisia" apparently controls most of our activities and our interests, it has not thus far succeeded in gaining a complete overlordship in the field of medicine. True, the use of the health claim for the advertising of antiseptics, tooth pastes, foods and most household utilities has become a popular means of approach to the "health-conscious" public. True, some clinics still promote their services to the indigent and the middle class by extensive announcements in the public press; for this, however, the plea of holy charity is used in extenuation. Again and again, advertising agents seeking some new outlet for the practice of their art have developed campaigns to be financed by medical societies or by individual physicians with a view to placing the wares of the medical profession before the public, as the services of musicians, plumbers, electricians and bakers are advertised. Thus far few medical societies of importance have succumbed to the lure of such promotions.

Several years have passed since various county medical societies in one of the states purchased space to announce some well established facts regarding the prevention of disease. The evidence thus far available indicates that the campaign was not particularly successful in enlightening the public or in bringing increased financial returns to the members of the societies that paid for the campaign. Not long ago several county medical organizations combined with some philanthropic organizations to promote a newspaper campaign for the advancement of the periodic health examination by the family physician, and incidentally by several pay clinics. As far as any information is available there is little evidence that this campaign resulted in any clearly defined saving of lives, any decreased morbidity or any increase in the emoluments of the medical profession.

Some time ago, a promoter of advertising by county medical societies submitted to the Judicial Council of the American Medical Association a series of advertising announcements with a view to finding out whether or not publication of such announcements would be considered an ethical procedure. Holding strictly to its function of passing on questions of ethics, the Judicial Council informed the advertising agency that it could see nothing fundamentally opposed to the principles of ethics in that series of announcements. The Judicial Council did not, of course, express

the individual views of its members as to whether or not in their opinions such an advertising campaign was advisable or likely to be of service either to the medical profession or to the public.

Reports have reached the headquarters office of the Association to the effect that the compilers and salesmen of this series of advertisements have been visiting newspaper editors in various communities with the suggestion that they induce the county medical society to purchase space for the publication of these announcements. It is reported that some of these salesmen have conveyed the impression that their entire plan has been officially approved by the American Medical Association. This is not true. It is also reported from some sections that officers of the medical society have then been informed that publicity would not be given to medical affairs in that community unless the medical society purchased the space for the announcements that have been mentioned. Thus what might be called a diplomatic manner of "bringing pressure to bear" has been used in an attempt to force the medical society into such expenditure of its funds.

THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION feels that expenditure of the funds of a county medical society for advertising announcements planned primarily to teach the facts of preventive medicine is not a proper expenditure for a medical organization. Medical education of the public is just as much a function of the press as education in the rules of contract bridge, the technic of golf or the proper training of children. The threat of any newspaper that it will omit scientific news of importance in the field of medicine unless physicians purchase advertising space is a idle threat. Any newspaper worthy of the name must publish scientific news. The vast majority of competent editors are convinced that few other news items are of equal significance at the present day. The newspaper that is dominated in its news columns by its advertising department is on the road to ruin.

The question of the publication of newspaper advertisements by county medical societies would appear not to be so much a question of medical ethics as one of common sense in the field of business. From this point of view, the burden is on the promoter to prove that the spending of money for such announcements provides an adequate return to the purchaser of the announcement, or to the public that such announcements are planned to serve.—Editorial, *Jour. A. M. A.*



**THE NEW SQUIBB BUILDING**  
A symbol of progress

Nearly 75 years ago, Dr. E. R. Squibb founded a modest pharmaceutical laboratory which was destined to become the modern institution of E. R. Squibb & Sons. Through each succeeding year the business has grown in size because it has grown in service.

In the course of rapid progress new buildings, new methods, new discoveries have constantly supplanted the old.

One of the recent evidences of growth is the new Squibb Building at 745 Fifth Avenue, New York City. Here are installed the executive offices of E. R. Squibb & Sons, in an impressive setting that is in keeping with the modern architectural development of New York City and in harmony with the steady progress of the House of Squibb in the industrial world.

#### **Disclosure of Diseases Under Prohibition Act Abolished**

Physicians who prescribe liquor need not state on the stubs of their prescriptions the ailments for which it is prescribed. The item on the stubs of outstanding prescription blanks calling for such information will be omitted. The Wickersham Commission, in its report released January 20, recommended that physicians prescribing under the National Prohibition Act be no longer required to state on blanks going into the public files the ailments for which prescriptions are

given. Two days later, the Commissioner of Industrial Alcohol issued a circular letter instructing all supervisors of permits under the act that ailments need no longer be stated on the stubs of prescriptions and directed them to advise the physicians in their several districts to that effect. Physicians are still required, by the National Prohibition Act itself, to keep in their offices book records of prescriptions for liquor, including records of the ailments for which it is prescribed, subject to inspection by prohibition officers.—*Jour. A. M. A.*, Feb. 7, 1931.

### Studies of Effect of Physical Therapeutic Procedures on Function and Structure

Harold Wolfson, Chicago (*Journal A. M. A.*, June 13, 1931), presents the results of a study of the effect of certain physical therapeutic procedures on the blood flow of a normal limb. He found that heat produces an increased blood supply due to active dilatation of the blood vessels. Massage and passive motion by mechanically emptying the blood vessels cause a temporary increase in the rate of flow. Electricity, as applied by the author, is ineffective in increasing the blood flow. Its value in the treatment of poliomyelitis and peripheral nerve injuries may be due to some other effects not studied in these experiments. A suggestion is made to use more frequent but shorter treatments of massage and passive motion. These observations should be of value as a basis of study of the physiology of the denervated muscle.

### Hemorrhagic Encephalitis After Neoarsphenamine

John W. Brittingham and Thomas Phinizy, Augusta, Ga. (*Journal A. M. A.*, June 13, 1931), report the case of a patient with sickle cell anemia who died following an injection of neoarsphenamine. The sudden appearance of a severe headache, vertigo, excitation and rapidly developing coma relegates this patient to the group of cases described as so-called hemorrhagic encephalitis. At necropsy, multiple hemorrhages into the brain and other viscera were seen. Microscopic examination of the tissues disclosed the typical finding of fat embolism. The authors believe that, in all cases presenting this syndrome, stains for fat should be done at necropsy.

### BOOK REVIEWS

*Clinical Dietetics.* By Harry Gauss, M. D., Instructor in Medicine, University of Colorado. Pp. 490, with 59 illustrations. Cloth. Price, \$8.00. St. Louis: C. V. Mosby Company, 1931.

The diets in this book are given in three forms: first, in detailed calculated form for medical students and dietiticians; second, as a week's menu; third, as a simplified text for the patient himself. This rather unique combination enhances the value of the book considerably. The text is conservative and very readable, and includes a brief but ample discussion of the medical and biochemical principles involved. Occasional case reports are included as well as the customary analytical tables. The special dietary requirements of the Jews are discussed most interestingly, but we could find no reference to it in the index except the word "Kosher." The book is of sensible length, and can be recommended heartily.

*Practical Preconception.* By William J. Robinson, M. D. Pp. 170, with 19 illustrations. Cloth. Price, \$3.00. Hoboken (N. J.): American Biological Society, 1929.

This is the fourth printing of Dr. Robinson's book on contraception. The work is entirely clinical and is based on the author's large experience. While no research work is included, there are very few statements to which the well-informed reader can take exception. The book is announced as being "for the medical profession only," yet the diction, in places, gives one the impression that the author has the lay reader equally well in mind, which after all is perhaps no fault in this sophisticated (?) age. The book is quite complete in its range, and lives up to its title in being practical; it is well worth reading by those interested in birth control.

*The Doctor and His Investments.* By Merryle S. Rukeyser, M. A., Associate in Journalism, Columbia University. Pp. 330. Cloth. Price, \$2.50. Philadelphia: P. Blackiston's Son & Company, 1931.

This financial mentor is written especially for the physician, and with his peculiar problems in mind. It contains the kind of advice that generally comes to the physician too late to be of maximum benefit. Its chief characteristics are, quite properly, conservation and a "balanced investment diet." All kinds of securities, realty, insurance, etc., are discussed profitably. The author is undoubtedly a keen analyst, and many of his phrases deserve to be popularized. Since the medical schools practically ignore medical economics and finance in their curricula the least they should do would be to present each student with a copy of this or some similar book as a Christmas gift in their fourth year; it would do a whole heap of good.

